OSCAR REISS, M. D. (1930 Wilshire Boulevard, Los Angeles).—The wide publicity given to height-weight-age tables as representing a correct index of nutrition has proved most unfortunate, for it has led far too many to believe that each individual child could be so developed as to reach "the average" established by these tables. And most parents wish and even believe it possible that their children can be made to reach above this average.

How firmly this notion is implanted in the lay mind is forcibly brought to our attention times without number. Hardly a day goes by but that one or more anxious parents appear in our offices imploring us to transform their perfectly fine but thin children into fat ones who will equal or surpass "average weights." How much of our time must continue to be spent carefully explaining that "every child is different," that there are hereditary limitations which cannot be overcome, and that a sense of well-being on the part of the child plus good muscle tone and tissue turgor, active response to environmental stimuli, good appetite and sleep, are far better indices of the nutritional state than conformity to height-weight-age tables.

Lucas and Pryor, in their paper, present a very simple and excellent method of classifying children according to inherited types of body build and by this means offer us a rational way of estimating the nutritional state.

The title of their paper sounds a truth that should be broadcast to all parent-teacher organizations, to all public health and school nurses, as well as to all associated with child-caring institutions.

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ANDREW J. THORNTON, M. D. (3235 Fourth Street, San Diego).—The standard chart of weight for height and age of children has been most unsatisfactory. The modified chart that takes into consideration the tall slender, the short stocky, and the average types has also been unsatisfactory. Therefore I welcome most heartily this paper by Lucas and Pryor, which suggests a way out of our difficulty.

In order that this new method of computing child nutrition may become practical and usable in our everyday work, it seems to me that a more simplified method of application will have to be worked out.

The general practitioner or the school nurse is not going to bother with a problem in decimal fractions in order to send home a report about a child, and these are the persons who are keeping the mothers of the country stirred up with their reports about underweight or overweight among school children.

I shall be greatly interested in further developments along this line.

VETERAN HOSPITALIZATION PROBLEMS*

By WILLIAM H. GEISTWEIT, JR., M. D.
San Diego

WHEN prosperity reigned and money was plentiful, taxes were just "one of those things"—an annoyance and a necessary evil. When business was booming, merchants and the professional classes had all the business they could handle; so loopholes in business, taxes, or paternalism in government were just incidents and nothing to worry about.

THE NATIONAL BUDGETS

But today the entire picture has changed. We find the entire national income has decreased from $85,000,000,000 in 1929 to less than $50,000,000,000 in 1932, a drop of more than 40 per cent. Contrasted with a vastly lowered income, nationally and individually, our tax bill has mounted until today it aggregates $10,250,000,000 for the federal, state, county, and municipal governments. Thus, in effect, every American works one day in every five, or sixty working days a year, to pay his taxes.

The picture up to this point affects every property owner and taxpayer. In this changed condition the medical profession has been as hard hit as any profession or business in the land. But from this point the brush begins splattering the medical profession, for the private practitioner not only pays his share of taxes, but a considerable amount of his tax money is used in financing government competition with him.

PRESENT COSTS OF THE CARE OF VETERANS

Witness: In the present budget there is an appropriation of $48,000,000 for hospitalization, domiciliary and medical care of veterans, and an additional $12,877,000 for hospital construction. By far the major portion of the first-named item is admittedly for the care of veterans whose injuries or diseases are in no way traceable to their military service.

EXTENSION OF CARE TO NONSERVICE DISABILITIES

The government's veteran disability policy, starting with the very proper care and treatment of those actually wounded, disabled, or sickened while in service, has been liberalized until it now includes hospitalization of men whose physical ills develop at any time, now or in the future. The result is that today the government owns and maintains 114 hospitals and domiciliary homes of which 69 are under the direction of the Veteran Administration, with 58,700 beds.

The menace of this liberal policy—the most surprisingly liberal in all history, as it pledges the government to perpetual care of the physical well-being of the veteran—not only to the treasury and taxpayer but to the medical profession, is evidenced by estimates of the medical council of the Veteran Administration that by 1950 there will be necessary 129,859 beds to care for the peak load of nonservice cases. This will involve, according to estimates based on present conditions, a cost for additional hospital construction of from $160,000,000 to $200,000,000, with an annual treatment cost of $140,000,000. Embraced in this statement is the thought of a corresponding loss to the medical profession and private hospitals.

Authorities estimate that if nonservice-connected cases are eliminated, instead of more construction being necessary, there would be an excess of 40,000 beds when the already authorized hospital building program is completed; and that it would be possible to close enough hospitals to save $30,000,000 in overhead alone. On October 31 last, there were but 29,106 service-connected cases occupying beds in hospitals administrated by the Veteran Administration, the remainder, of course, being of nonservice disabilities or diseases.

* From the office of the secretary, San Diego County Medical Association.

THE MEDICAL PROFESSION AND THE GREAT WAR

No group suffered more than the medical profession during its war service, so no one can accuse it of lack of sympathy for those who fought and were disabled thereby. But the profession is unalterably opposed to governmental care of nonservice-connected disabilities, especially when the veteran is able to pay his way. What is just for the veteran is just for the civilian who saw no service. If competition with the medical profession and the hospitals on the part of the Federal Government is just, then the grocer, the clothier, and all the rest should be subject to the same treatment. The mere fact that a man did his duty overseas does not warrant perpetual care by the government while the man is neglected who performed the necessary civilian duties at the home base or who because of age, disability, or lack of opportunity for duty could not serve. The veteran with service-connected disability might receive a more just compensation for his blighted career if his comrades discharged unscathed, especially those able to pay their own way, were not putting the whole veteran group in a bad light by demanding free care.

EFFECTS UPON HOSPITALS AND MEDICAL PROFESSION

The effect of one phase of this policy on the medical profession and the nation's great private hospital business of more than 2,000 institutions, as well as a suggested road out, constructively planned, is succinctly told in a nonprofessional publication, *The Saturday Evening Post,* which, in an editorial in its January 7 issue, said:

Hospitals throughout the country are feeling the cramping effect of current conditions more severely than almost any other class of institutions. Even in good times they are run at a loss and must look to charitable citizens and to local welfare organizations to meet their deficits. This winter they are under pressure to give more free service than ever, with fewer paying patients to offset their costs.

Medical men, even those with large practices, are feeling the pinch of poverty, for they report they are collecting only from 10 to 20 per cent of their bills. Doctors and surgeons may starve, hospitals may go broke, bnt such are the traditions of medicine that the sick must be cared for at any cost.

Our hospital situation is becoming more and more grave. Only five-eighths of our existing accommodations are being used. More than three-eighths of the available beds—38 per cent, to be exact—are empty. In the face of those conditions, Congress, with its unfailing genius for devising new ways in which to spend other people's money, threatens to make them worse by building all over the land elaborate and costly hospitals for the care of sick and disabled veterans.

Such a course is as detrimental to the best interests of the veteran as it is to sound public policy. Already there have been bitter complaints from the mothers of veterans that their boys have been sent to hospitals so far from home that it is impracticable for their families to visit them. Such complaints are well founded. They will multiply in proportion as the practice becomes more widespread.

Veterans are entitled to care as near home as hospital facilities permit. It is manifestly unfair to send them to distant medical centers for treatment when they can be given as good care among friends and neighbors, where their families can visit them without inconvenience or expense and where they can still have some share in home-town affairs. Local hospitals are local enterprises and they are usually sponsored by the best element in their communities. The government, instead of setting up destructive competition with these quasi-charities, should utilize their vacant accommodations and pay a fair price for the service rendered. Such a policy would be of interest to veterans and would react favorably upon struggling institutions from coast to coast.

That is just half the story. The other half is effectively stated by Dr. Thomas W. Bath of Reno in a report to the Nevada Medical Society from its Military Affairs Committee, in this wise:

There can be no other interpretation to the work of the Veterans' Bureau than to class it as in the business of state medicine. State medicine is an affair which every group of ethical men and women in the practice of medicine or nursing is vigorously fighting today. Every sick soldier or nurse has the supreme right to call to his bedside such physician or surgeon as is his or her choice.

Under the present plan the government is entering into business in direct competition to today's number of 156,440 physicians and surgeons, not to speak of tens of thousands of nurses. The government's bureau is attracting to itself a medical and surgical clientele from over 4,000,000 people, thereby taking away from the legitimate earnings of thousands of physicians, surgeons, and hospitals.

In addition, let me point out that the present hospitalization is ineffective, despite its liberality, because acute cases cannot be as quickly and efficiently handled in government hospitals, scattered as they are throughout the land, as in local, private hospitals in the very community where the case originates.

Now back to the principal thought—the cost of all this present paternalism of the government.

The plan of hospitalization and medical care today costs every family in America at least $10 a year, and if outlined plans are approved the cost will be tripled. As expressed in Doctor Bath's report in the December CALIFORNIA AND WESTERN MEDICINE, page 370:

But we must not consider that this tax would be spread upon a pro rata or general average; for it is estimated that 3 per cent of the population of the United States pays the bulk of the government tax, while 12 per cent of the population makes up the entire remainder.

Thus the battle of the budget, now being fought out before congressional committees in Washington, has an importance to the taxpayer, and the physician taxpayer, never before attached to such hearings.

NATIONAL ECONOMY LEAGUE [1]

Directing this battle for the taxpayer, and incidentally for our profession, is the National Economy League, whose representatives have already demanded a budget cut of $450,000,000; a change in the method of hospitalization; and the complete halting of hospital construction plans. This organization is fighting the good fight for the whole country, for the very financial stability of the nation, because taxes even now are so burdensome that hundreds of thousands of property owners have defaulted. What will it be when new taxes are needed not only to balance the budget but to meet the new raids on the treasury contemplated by the politicians who in many instances are utilizing the veterans for selfish aggrandizement?

[1] Concerning the National Economy League, see California and Western Medicine, December, 1932, page 425.

ACTION OF THE SAN DIEGO COUNTY SOCIETY

The San Diego County Medical Society, of which the writer of this article is secretary, fully realizes the principles embodied in this battle, and believes that now is the time to organize and make articulate the entire profession and the taxpaying public in order that the problem may be solved immediately and rightly. To this end the society is throwing its support behind the National Economy League, whose leaders embrace such distinguished figures as Newton D. Baker, Elihu Root, Alfred E. Smith, General John J. Pershing, Rear Admiral Richard Byrd, and Admiral Sims. To do otherwise is to court financial disaster for the country and the erection eventually of a real trust in state medicine, as opposed to the private practitioner and hospital. May I suggest a vigorous course of action by every medical society?[2]

233 A Street.

DOCTORS AND CLINICS

By C. L. MULFINGER, M. D.
Los Angeles

DURING the past two years economic aspects of the practice of medicine have received more attention in public discussion than at any time within the knowledge of the present generation. Various surveys have been undertaken—local, state, national, and even international—with a view of arriving at an accurate estimate of the costs of medical care. In these surveys special attention was paid to the remuneration received by the physician and to the cost of hospitalization and accessory expense to the patient. One thing, however, has been overlooked in these surveys, and that is, the amount of gratuitous services rendered by the medical profession. The briefly published reports of tax-supported institutions are much in evidence in these surveys, but little information is given about the numerous clinics which are privately supported and have staffs of devoted attending physicians who give freely and without public recognition of both their time and service to the care of indigent and near-indigent citizens.

PURPOSE OF THIS PAPER

This article may be regarded as an attempt to show briefly the amount of charity work done by attending physicians in seven of these privately supported clinics in the Los Angeles metropolitan area, especially pointing out the mounting figures of the last three years. For the purpose of making the report on this question reliable, a brief questionnaire was sent out to the ten largest privately conducted clinics in the Los Angeles area. Of these, seven answered the four brief questions which were submitted to them.[1] These questions were:

1. How many patient visits per year have you had in your clinics for the past three years?
2. How many doctor hours per year for the past three years?
3. Has the social status of your patients changed noticeably in the past three years?
4. What is the average charge per patient made?

The answers received were as follows:

I. CLINIC PATIENT VISITS

	1929-30	1930-31	9 months only 1931-32
Clinic No. 1..	51,932	57,166	70,224
Clinic No. 2..	2,399	8,250	8,513
Clinic No. 3..	10,357	12,694	16,453
Clinic No. 4..	34,104	35,964	43,844
Clinic No. 5..	23,225	23,225	23,225
Clinic No. 6..	26,815	28,628	30,898
Clinic No. 7..	71,123	90,946	115,000 estim.
	219,961	256,873	308,157

II. DOCTOR HOURS

	1929-30	1930-31	1931-32
Clinic No. 1..	7,616	7,616	7,616
Clinic No. 2..	No record		
Clinic No. 3..	No record	1,617 (ten mos.)	3,147
Clinic No. 4..	6,097	6,097	6,097
Clinic No. 5..	3,612	3,612	3,612
Clinic No. 6..	2,989	3,910	5,503
Clinic No. 7..	10,812	10,812	15,812 estim.
	31,126	33,664	41,787

These figures show an increase of clinic patient visits of 50 per cent in 1931-1932 over 1929-1930. For this increase in patient visits at the clinic there has been a corresponding increase in the number of doctor hours which amounted to almost 33 per cent.

MONEY VALUE OF THE SERVICES DONATED BY PHYSICIANS

Several years ago the Fee Schedule Committee of the Los Angeles County Medical Association estimated that the doctor's hour should be worth $12 to the patient. This was considered a conservative estimate. Taking this as a basis of calculation, it would follow that, in the seven clinics whose reports were submitted, the physicians rendered $501,447 worth of service to the general public in 1932; and if all the free or part free clinics in this area were included in our report there is no doubt that the sum of the service rendered gratis would mount up to $1,000,000 for the current year.

The lay public knows nothing of this service nor reads a public record of it. If some philanthropist or philanthropic organization were to give

2 The Southern California branch of the National Economy League has just been organized, with headquarters at 548 South Spring Street, Los Angeles. Membership enrollments may be sent to that address or by telephone, Mutual 2289. Membership is without obligation, the organization being supported by voluntary contributions. Its purpose is to fight extravagance in all phases of local, state, and federal government. The matter discussed above is only one of its efforts. Additional facts and figures may be found in the American Medical Association Bulletin of November 1932, pages 199 ff., being abstracts from General Frank T. Hines' address, "The Major Problems of Veteran Relief." See also December, 1932, California and Western Medicine, page 425.

1 A questionnaire survey of some Los Angeles clinics. The clinics whose social departments and directors have furnished the writer with the above facts are: All Nations, White Memorial Hospital Clinic, Santa Rita, Children's Hospital Clinic, Pasadena Hospital Dispensary, Orthopedic Hospital Clinic, and Eye and Ear Hospital Clinic. For their kindness and helpfulness the author wishes to express his gratitude. All these clinics are members of the Los Angeles Community Chest, with the exception of the Pasadena Hospital Dispensary, which is a member of the Pasadena Community Chest.